

Child Guidance Clinic Policy and Practices

THIS REVIEW of the personal, physical, psychological, and social characteristics of patients seen in the Los Angeles Child Guidance Clinic attempts to ascertain whom the clinic served and to derive, as far as possible, some ideas of the problems most suitable for child guidance clinic services, the procedures of intake and of closing cases, and how worth while the work of the clinic seemed to be.

The 500 cases studied were divided into two groups: 450 successive cases for which full responsibility was taken by the clinic and 50 cases for which major responsibility was taken by some other agency. In the latter, known as cooperative cases, the major role of the clinic was that of consultant and, sometimes, provider of continued psychiatric treatment.

All evaluations of medico-psychiatric procedures were the responsibility of the psychiatrist, who had had a major administrative responsibility for overall policies of the clinic for many of the preceding years. The procedures of experienced social research were applied, and a rather large listing of problems by category was worked out.

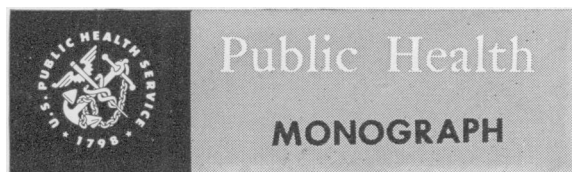
Some of the more significant conclusions reached and further questions raised were:

1. About 12 percent of the cases were considered unequivocally successful and 47 percent, partially successful. Criteria applied were disappearance or diminution of symptoms, clarification of parent-child relationships, insight into problems by patient or responsible adults, and clarification of problems to agencies.

2. Sharp clarification of the basic orientation of the agency. Is it primarily medical or psychiatric or social casework? What evidence is there that the clinic team functioned to best advantage? The conclusion was that only about one-fifth of the cases clearly called for a team approach; the others seemed to warrant referral

to casework agencies, private psychologists, school clinics, or other facilities not involving the specialized expense and complexity of the child guidance clinic.

3. What should be the relationship of the child guidance clinic toward other agencies in the community? Integration into the work of a health and welfare agency? Or should it



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The accompanying summary covers the principal findings presented in Public Health Monograph No. 42, published concurrently with this issue of Public Health Reports. At the time of the study, the authors were with the Los Angeles Child Guidance Clinic, Los Angeles, Calif.

Readers wishing the data in full may purchase copies of the monograph from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. A limited number of free copies are available to official agencies and others directly concerned on specific request to the Public Inquiries Branch of the Public Health Service. Copies will be found also in the libraries of professional schools and of the major universities and in selected public libraries.

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Anderson, Forrest N., and Dean, Helen C.: Some aspects of child guidance clinic intake policy and practices. Public Health Monograph No. 42 (Public Health Service Publication No. 485). 16 pages. U. S. Government Printing Office, Washington, D. C., 1956. Price 20 cents.

remain somewhat isolated as a highly specialized technical service?

4. Who should refer cases to the clinic? Is it desirable to have parents apply directly for clinic service when only a very small number of cases can be served in a huge area? Or should referrals come through physicians or professional agencies in which some degree of preliminary screening has been done?

5. The question of the suitability of many cases for clinic service is raised since 31 percent of the cases were closed out for reasons which amounted to "against the advice of the clinic."

6. What evidence is there that cases referred on the basis of symptoms which fall into certain categories are more amenable to treatment than other cases? That is, are cases in which symptoms are concrete, specific items of undesirable behavior more treatable than those in which symptoms are described in terms of generalized abstractions or "cause"?

The study does not give any definitive answers but is believed to raise a number of significant questions, with sufficient data on many of them to provide a basis for further studies.

Confirm Efficacy of Salt and Soda Solution

Clinical tests have confirmed the earlier laboratory findings of three Public Health Service scientists, Dr. Sanford M. Rosenthal, Herbert Tabor, and R. Carl Millican, that oral consumption of salt and soda solution in large amounts is an effective emergency treatment for shock due to burns.

The tests were conducted in Lima, Peru, by Peruvian and American scientists, headed by Dr. Kehl Markley, under the sponsorship of the Public Health Service. Reporting in the *Journal of the American Medical Association*, August 11, 1956, they said no toxic effects from the use of the saline solution, even though it was administered in large amounts, were observed in any of the 193 severely burned patients.

A simple, effective procedure for treatment of shock, which so often kills victims of severe burns during the first 48 hours after injury, is particularly valuable in a major disaster. As the saline solution may be prepared easily of materials available in almost every home (table salt, baking soda, and tap water) the method may save many lives in disasters when skilled medical care is not promptly available.

Shock formerly caused countless deaths among victims of burns and other types of injury. During the past 20 years, intravenous injection of whole blood, plasma, or the so-called plasma extenders has proved effective

in preventing such effects of shock. The difficulties of intravenous therapy, however, are considerable, and they are overwhelming in a major disaster.

Even today, a high proportion of early deaths among victims of burns covering 10 percent or more of the body area is attributable to shock. The trauma induces a state of profound physical and mental depression, usually 3 to 5 hours following injury. Its chief features include the following: marked fall in blood pressure; feeble and rapid pulse; decreased respiration; a sudden and intense, although incomplete, suspension of vital body functions; and, sometimes, unconsciousness. The victim's skin is pale and clammy. In burns, loss of circulating body fluids sets up an immediate and pressing need for replacement.

The saline solution used during the clinical tests may be approximated, for emergency purposes, by dissolving a teaspoonful of table salt and one-half teaspoonful of baking soda in a quart of drinking water. The patient should be encouraged to drink as much as he can of this solution. Of course, liquids should not be given to persons who are unconscious or who cannot swallow. A victim of burns may require as much as 6 or 7 quarts or more during the first 12 hours following injury.